DOCUMENT RESUME

ED 267 129 UD 024 715

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TITLE Evaluating Mental Health Services for Southeast Asian Refugees: Cross-Cultural Methodological Issues.
PUB DATE 85
NOTE 36p.; Working paper prepared for the Pacific Asian American Research Method Workshop (Ann Arbor, MI, July 29-August 23, 1985); and the Annual Convention of the American Psychological Association (Los Angeles, CA, August 23-27, 1985).
PUB TYPE Reports - Evaluative/Feasibility (142) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Acculturation; Anxiety; *Asian Americans; Depression (Psychology); *Evaluation Methods; Immigrants; *Mental Health Programs; Program Evaluation; *Psychological Services
IDENTIFIERS Southeast Asians

ABSTRACT

The study evaluates the effectiveness of two bilingual, non-traditional mental health peer counseling type programs providing services to Southeast Asian refugees in the Minneapolis-St. Paul metropolitan area. This area has the second highest per capita rate of Southeast Asians in the nation and as these refugees have, in general, experienced a great deal of emotional trauma, chronic stress, personal hardship, and family disruption prior to resettlement, they are frequently in need of mental health facilities to treat depression and anxiety, situational disorientation, and grief reactions. The study sample consisted of the 150 clients entering the two programs from July 1983 through December 1984. The evaluation instruments included a 70-item problem checklist for the counselors to fill out; a 20-item depression scale for cross-cultural use; and a background information form which gathered information on the clients' previous experiences including traumas and stresses, previous mental health history, proficiency with English, and various sociodemographic indicators. Preliminary results indicate that factors such as income, employment, age, length of treatment, English ability, and length of time in the United States do not appear to be related to treatment outcome. Ethnic group, receiving government assistance, and a number of traumatic experiences were tenuously related to outcome for one of the two agencies. It is concluded that treatment outcome is very hard to relate to client variables and further analysis of the data is needed. The paper includes extensive tables outlining the findings. (CG)

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Evaluating Mental Health Services for Southeast Asian Refugees: Cross-Cultural Methodological Issues

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UD024715

Evaluating Mental Health Services for Southeast Asian Refugees: Cross Cultural Methodological Issues

Abstract

Southeast Asian refugees have experienced a high level of trauma, stress, hardship, and family disruption while settling in the U.S. These factors, in addition to significant dissonance between Asian and American cultures, frequently result in a high rate of depression and anxiety, disorientation and grief reactions.

The methodological issues involved in designing and implementing an evaluation study of two mental health programs for Southeast Asian refugees will be discussed in some detail. The evaluation design, and some preliminary results are also presented.

Evaluating Mental Health Services for Southeast Asian Refugees
Cross-cultural Methodological Issue

Introduction

Southeast Asian refugees have recently settled in the Minneapolis-St. Paul area of Minnesota in significant numbers; this area has the second highest per capita rate of Southeast Asians in the nation. Refugees from Southeast Asian have, in general, experienced a high level of emotional trauma, chronic stress, personal hardship, and family disruption prior to resettling in this country. These factors, in addition to significant dissonance between Asian and American cultures, frequently result in a high rate of post-settlement depression and anxiety, situational disorientation, and grief reactions.

The resettlement of refugees is a complex and extensive process.

> On the road toward integration, stress is constant, prolonged and severe. Casualties are to be expected. They are frequent and diverse in nature and in severity, but not necessarily inevitable. Damage can be manifest in terms of psychiatric symptoms, physical illness, interpersonal difficulties, acting-out, social maladataption...singly or simultaneously. All could, and do, undermine the individual's capacity for functioning in an effective fashion. (Tung, 1980).

Over time, mental health needs may emerge as even more severe than during the initial post-settlement period.

> Despite the enormous strains of the adjustment process, a considerable number of refugees are <u>most</u> vulnerable to depression <u>after</u> the more immediate tasks of resettlement are completed--
> when the needs for food, clothing, housing, work, etc. are satisfied--and the newly settled refugees have time to reflect more deeply on their ordeal. In this period, the need for counseling and support is great. (Robinson, Note 1)

Studies of refugee mental health have not been reported in any systematic fashion. Very few studies have reported patterns of service utilization and outcome for Southeast Asian refugees in the United States (Van Deusen, 1982). It seems, however, that refugees tend to "under-utilize" formal health care services--at least relative to their report of problems (Van Deusen and Lappin, cited in Van Deusen, 1982). Van Deusen reports on a study of Vietnamese refugees in Los Angeles (Le, cited in Van Deusen, 1982) which shows that most informants would prefer to use family or friends as a primary source of help for mental health problems, sustaining a tradition from the homeland. This fact, in combination with difficulties in communicating with American providers, contributes to their "under-utilization" of services (Van Deusen, 1982).

Cohon (cited in Van Deusen, 1982), in a preliminary report of mental health services provided by a special project in the San Francisco area during 1976-1977, reports on 54 Southeast Asian patients being seen by Southeast Asian paraprofessional trainees working under supervision. By their second year in the United States, depression appears to have emerged as a primary problem in approximately half of the San Francisco patients. After 2 1/2 years, virtually all of the San Francisco clients exhibited depression as a primary problem. Counseling by the paraprofessionals averaged three visits over five months. After this time, ratings by the paraprofessional trainees showed 67% of the clients improved. The ratings are congruent with the views of the patients, 65% of whom felt that the services helped them.

According to Van Deusen, between 1976 and 1981, state and federal grants and contracts have supported over 50 model mental health and

training programs to serve the Southeast Asian refugee population in the United States. Descriptive and evaluative reports have been published for only a handful of those ventures.

Description of Programs

This paper will present the methodology and design of two programs providing mental health services to Southeast Asian refugees in the Minneapolis-St. Paul metropolitan area. Both mental health programs are affiliated with the University of Minnesota and/or the Amherst H. Wilder Foundation, a large operating foundation providing human services in the St. Paul metropolitan area. Funding for the evaluation projects was provided by three general sources:

(1) The U.S. Office of Refugee Resettlement, Department of Health and Human Services, Social Security Administration, Washington, D.C.,

(2) Refugee Program Office, State of Minnesota,

(3) Amherst H. Wilder Foundation.

Agency 1 (the Community University Health Care Center, Minneapolis, MN) and Agency 2 (Social Adjustment Program for Southeast Asian Refugees, St. Paul, MN) provide direct mental health services to Southeast Asian refugees via bilingual counselors representing the Hmong, Cambodian, Lao and Vietnamese communities. These bilingual counselors have been trained by both programs to listen and provide acceptance and emotional support, assist the person to problem-solve, and find appropriate help from other professionals, agencies, and natural helpers in the community. In addition, these bilingual counselors attempt to serve as a bridge or link

between professional mental health services and indigenous sources of care giving. This role corresponds closely with the role of persons labeled "peer counselor," "paraprofessional caseworker," or "patient advocate."

Purpose of Evaluation

The purpose of the evaluation study is to assess the effectiveness of these two non-traditional mental health programs providing services to Southeast Asian refugees. More specifically, the evaluation attempts to determine:

(1) the amount and type of services delivered (e.g., individual therapy, couple/family therapy, psychiatric assessments).

(2) the socio-demographic characteristics of refugee clients (e.g., age, sex, marital status, income, number of children, education, fluency with English, etc.).

(3) the incidence and severity of depressive symptoms among the Southeast Asian client population as measured by the Walton and Brantner Depression Scale For Cross-cultural Use and the Problem Checklist.

(4) the effectiveness of mental health services in reducing the level of depression in the refugee persons served.

(5) the incidence and severity of problems among the Southeast Asian client population as measured by bilingual counselor ratings on the Problem Checklist.

(6) the effectiveness of mental health services in reducing the severity of the targeted problems among refugee clients.

(7) the satisfaction of clients with mental health services.

(8) the relationship of sociodemographic characteristics, type and amount of service, type and severity of problem to treatment outcome (i.e., level of depression, severity of problem, client satisfaction).

(9) the use of indigenous "natural helpers" within the Southeast Asian community in the mental health treatment of clients.

Research Methods

Sample

The sample consists of 150 clients of the two mental health programs. This sample represents all the Southeast Asian clients entering the two programs during a six month period of time from July 1983 through December 1984.

Instruments

Several evaluation instruments were created for use specifically with this client population. These instruments were developed in conjunction with bilingual program staff and needed to be translated and back-translated into the four relevant Southeast Asian languages. Developing culturally relevant instruments and designs was extremely difficult. This difficulty was exacerbated by the fact that even though this cross-cultural research called for a more unstructured and qualitative approach to evaluation, the language problems of the bilingual counselors demanded a structured, quantitative approach requiring little English use.

The evaluation instruments used were: Problem Checklist, Walton and Brantner's Depression Scale for Cross-cultural Use, and Background Information Form.

Methods

The Southeast Asian Problem Checklist is a 70-item instrument which asks bilingual counselors to rate their clients on a series of mental health problems (e.g., marital problems, crying, headaches, etc.). It is based on a similar measure developed by the Indochinese Mental Health Program of the International Institute of San Francisco.

Walton and Brantner's Depression Scale for Cross-cultural Use was developed in response to expressed clinical dissatisfaction with Western psychopathology scales, even when they were well-translated. Items were gathered from Walton and Brantner's extensive clinical experience with depressed Southeast Asian clients, standard mental health scales and a nursing study on well-being. Items were clarified, translated and back-translated by 11 bilingual counselors to form a final 20-item scale. This scale has not been used previous to this research.

The Southeast Asian Background Information form gathers background information about the client's previous experience, including traumas and stresses (e.g., death of family members, torture and imprisonment, separations, living in refugee camps, etc.), previous mental health history, proficiency with English, and various sociodemographic indicators (such as age, sex, income, education, government assistance, ethnic group, employment status, time in U.S., etc.). Table 1 highlights the research design and the instruments used.

Table 1
Design of the Evaluation of Two Agencies Providing Mental Health Services to Southeast Asian Refugees

AGENCY 1	AGENCY 2
* Located in Minneapolis, MN * N = 50 clients (collected over a 6-month period, July-December 1984)	* Located in St. Paul, MN * N = 100 clients (all clients admitted over a 6-month period, July-December 1984)

RE-TEST INSTRUMENTS: Collected by bilingual counselor at the beginning of treatment

1. Walton and Brantner's Depression Scale for Cross-cultural Use

    * 20 items
    * Reliability (K-R 20) coefficients
    * True-false format

2. Problem Checklist

    * 70 items
    * Extensive list of problems under the following headings:

        Physical problems (e.g.,
        Mental health problems (e.g.,
        Family problems
        Socialization problems
        Practical problems
        Chemical abuse problems
        Language ability

3. Traumatic Events List

    * 13 items (e.g., being tortured, imprisonment)

4. Other Variables

    * Sociodemographic (e.g., ethnic group, age, sex, income, etc)
    * Client's report of problems

POST-TEST INSTRUMENTS: Collected by bilingual counselor 6 months after treatment began.

    * All relevant pre-test instruments were re-administered.

Design

All data was collected on clients before (pretest) and 6 months after (post-test) their participation in the various mental health programs. Data was provided by the bilingual counselors providing services and by the clients themselves. Thus, perspectives on clients' problems and outcomes are gathered from two perspectives: the client her/himself and the bilingual worker.

Underlying Goals of the Research

Although the specific purposes of the evaluation study have been explicitly stated in the previous section, there were three less explicit goals that guided the design of this evaluation study. These underlying goals are related to the author's theory and method of doing evaluation.

Goal 1: To develop instruments and a research design that would be useful clinically.

An explicit attempt was made to develop evaluation instruments that would be useful to the bilingual counselors providing treatment to the refugees. Instruments were designed to be used for clinical intakes, treatment planning, and client assessment. To accomplish this end, instruments were designed with frequent staff and bilingual worker input.

Goal 2: To develop instruments and a research design sensitive to cross-cultural issues.

The cross-cultural research issues involved are extremely complex and involve such concepts as the emic-etic distinction (Triandis & Brislin, 1984), functional, conceptual and metric equivalence and the biases, ignorance, and assumptions of the Caucasian-American principal investigator.

Nevertheless, attempts were made to pick methodology and concepts appropriate to this population. Many meetings were held with bilingual counselors and agency staff to evaluate various aspects of the instruments and design. At these meetings, bilingual counselors were encouraged to be frank in their assessment of the instruments and research design. Instruments were piloted for one month to correct any problems in administration or meaning.

Once the first phase of data collection is complete, the evaluation design and instruments will be revised after meetings with bilingual staff of both agencies, who will be encouraged to ask for feedback from clients.

Goal 3: To answer some questions of general scientific interest regarding the mental health treatment of Southeast Asian refugees.

The therapy outcome research literature has examined the effect of several variables on the success or outcome of treatment (e.g., length of therapy, social class, educational status, age, sex, personality, test patterns, symptoms of anxiety and depression, client disturbance, ego strength, IQ, client expectancies concerning therapy, type of therapy, attractiveness, reliability, likeability, etc. (Garfield, 1978). In this study, some similar variables will be examined to compare the relationships between client variables and outcome in American client samples with those same relationships in the Southeast Asian client sample. Such client variables as income, trauma, English ability, sex, government assistance, ethnicity, education, and employment status will be examined to see if they are related to treatment outcome (e.g., Do clients with higher incomes seem to do better in treatment?).

Methodological, Cross-Cultural, and Other Problematic Issues

Rather than focus only on the results of the evaluation study, I will spend much of the time discussing the process of developing a cross-cultural evaluation and some of the problems inherent in such a task.

Neither Fish Nor Fowl

Designing an evaluation study of Southeast Asian refugees requires the researcher to be knowledgable about the native culture of the refugees, the U.S. culture, and, most importantly, the interaction of the two cultures. This knowledge base is not readily available. One reason is that Americans have limited access to codified knowledge about Southeast Asia. This point is documented by Favazza and Oman (cited in Van Deusen, 1982) who searched the anthropological and psychiatric indexes for the years 1924-1974. Out of 555 citations for Asian cultures, only two covered Vietnamese culture. Since the Indochinese refugees have only recently migrated to the U.S., very little is known about the interaction of Indochinese and American culture; we have simply not had enough time to experience, no less evaluate, this cultural interaction.

Thus, researchers working in this area are handicapped by the lack of knowledge and will have to learn from their mistakes, and the mistakes of others, as well. I knew very little about the Southeast Asian culture

when I undertook this project. I still don't know enough, but I do know quite a bit more than when I started.

Does Cambodian = Hmong = Laotian = Vietnamese?

The Indochinese or Southeast Asian refugees are a diverse group of people from Vietnam, Cambodia, and Laos. They also represent several other ethnic minorities including Chinese, Hmong, and Mein. There exists cultural and language differences among the groups and some historical antipathy between various groups. For the purposes of this evaluation, four groups were examined: Vietnamese, Cambodians, Laotians, and Hmong. Each group forms a sizeable and distinct community in the Minneapolis-St. Paul metropolitan area.

Needless to say, this diversity presents additional problems for the researcher, as well as the clinician. Specific knowledge about the history and culture of each of the four ethnic groups is desirable. This is not a trivial problem. It takes many years of study to become familiar with the various Indochinese cultures and to really understand them.

Furthermore, the complexities of accurately classifying ethnicity is just as problematic among Indochinese as among U.S. ethnic groups.

> How does one classify Chinese who grew up in Vietnam, attended Chinese school and cannot speak Vietnamese fluently? Does is matter that to the Chinese, he is perceived as Vietnamese and to the Vietnamese, he is perceived as Chinese? Is self-definition of ethnic identity preferable to racial or biological definitions of identity?" (Yu & Lui, 1985, p. 9-100.

For this study, the bilingual counselor's definition of ethnic identity was used. It is not clear what criteria they used to classify

ethnicity. Further information on that issue will be gathered when the evaluation undergoes revision.

Evaluation as an Alien Idea

The entire notion of research and evaluation is one that is not familiar to many Southeast Asians and may have negative connotations for them. Oral consent to participate in the evaluation was obtained by the bilingual counselors. These bilingual counselors were careful to avoid the use of the term "research" when asking their refugee clients to participate in the study. They felt the use of the term "research" might elicit negative reactions. For instance, the refugee clients might feel that they were being "experimented on" instead of getting the services they were requesting. Bilingual counselors were so successful in gaining consent of virtually all their clients, that some concerns about the adequacy of the informed consent procedure have been raised. Perhaps refugee clients were not adequately informed of the voluntary nature of their participation. The adequacy of the informed consent procedure will be examined in more detail when the evaluation instruments are revised.

Other researchers have discussed the issues involved in obtaining informed consent from populations who have not had much experience with research and/or have experienced very traumatic and threatening life experience. Yu and Lui (1985) expressed concern about the concept of informed consent when working with special populations (e.g., the poor, uneducated, and recent refugees) and discuss their experience in obtaining written consent from their Vietnamese sample. However, the problems these researchers encountered in their survey of Vietnamese refugees were of an opposite nature to our experiences in this

evaluations study; they had difficulty in obtaining consent from their survey sample. These different experiences can be partially explained by the different contexts of the two studies. In this evaluation study, data was collected by bilingual counselors providing mental health services voluntarily requested by the refugees. Data collection was designed to be an integral part of normal agency intake procedures. Yu and Liu were doing large-scale survey research in the Vietnamese community. They were randomly selecting respondents, setting up appointments, and asking for written consent.

Yu and Lui (1985) sum up the major issue succinctly;

> The subsequent refinement of survey techniques in this country has generally educated Americans and taught them to be more responsive to research inquiries. However, the vast majority of Asian ethnic minorities in this country, especially Indochinese refugees who fall outside the mainstream of American life, are not yet informed of the concept of social surveys, nor do they fully understand the role of research interviewers. (p. 5)

Because the Southeast Asians have had little exposure to evaluation and research, their responses to research procedures is not well known. Berry (1980) suggests that response styles (e.g., acquiescence, extreme checking styles) social desirability and demand characteristics may operate more or less extremely among Asian populations. Chung (Note 2) hypothesizes that acquiescence and the tendency to respond in a socially desirable manner will be stronger among Asians. Chang (1985) contends that people of different cultures are likely to respond differently to any given situation, partially because the "demand characteristics" (i.e., the configuration of stimuli present

in psychological studies involving human subjects) are perceived differently by people of different cultures.

It would be invaluable if more information about the cultural variations in response style were available. Berry (1980) points out how much we have to learn in this area.

> It would be useful if generalizations were available to guide the researcher, such as 'acquiescence tends to be high in cultures of type A....; but this information simply does not exist (p. 18).

The Language Barrier

Current thinking in cross-cultural research begins with the expectation that concepts will not have the same meanings across cultures (Triandis & Brislin, 1984). While there may be some identical aspects to a concept such as depression (which was an important concept examined in this evaluation study), there will also be a culture-specific meaning. This is part of what has been called the "emic-etic distinction" (Berry, 1980, Triandis & Brislin, 1984);

> The terms are borrowed from linguistics where a phonemic system documents meaningful sounds specific to a given language. A phonetic system organizes all sounds which have meaning in any language. For Psychology, then, the emic-etic metaphor suggests that culture-common (etic) and culture-specific (emic) aspects of concepts should be expected and sought (Triandis & Brislin, 1984, p. 1009).

This problem of different meanings for what appears to be the same concept, is compounded when translation from one language to the other is attempted. Several techniques have been suggested as ways to make translation more accurate. "Back translation" and the newer technique of "decentering" have been suggested as well as the idea that translators

should play a role more like collaborators in research (Triandis & Brislin, 1984).

Specific translation problems that occurred in this study illustrate a few of the issues involved. First and foremost, the problem of translation was compounded by the fact that the Southeast Asian refugees studied were composed of four different groups speaking four distinct languages. At least four translations are required which increases the complexity and possible non-equivalence of these translations. On a practical level, the costs, in both time and money, to develop translations are also significantly increased especially if one follows Triandis and Brislin's (1984) suggestion of forming a collaborative relationship with the translators. Routine tasks like typing and proofreading become difficult. Cambodian and Lao do not use Latin script and cannot be typed or word processed on standard office typewriters. Typing and translation errors become much more difficult to detect than in other languages.

Translation problems with the Hmong version of the Walton and Brantner Depression Scale for Cross-Cultural Use appeared to be particularly problematic. The translation of the Hmong version of this instrument was constantly being revised as soon as a new Hmong translator looked at the instrument. It was never quite clear to me what the problems with the translation of the instrument were, but after much discussion with my translator-collaborator, I generated a plausible hypothesis. Hmong has primarily been an oral, not a written language. Christian missionaries had only recently developed a Latinized script for the Hmong language, which is known by a few Hmong people. Because of the

relative newness of the written version of the language, several of the Hmong bilingual counselors, who were doing some translation, may not have been as proficient and familiar with the language as others, or perhaps the rules for structure and grammar are not as rigidly defined as English-speakers might expect.

The use of Hmong illustrates some difficult political problems for the researcher. Most Hmong people are illiterate in Hmong. A larger number know how to read and write Lao as a result of education in Lao schools (Westermeyer, Vang & Lyfong, Note 3). However, the decision to create separate Hmong and Lao versions of the instruments was made because of the Hmong people's strong feelings of ethnic identity and pride. For centuries, the Hmong have fought to maintain their independence as a distinct ethnic group; separate and distinct from the lowland peoples such as the Laotians. They have often united under temporary leaders for wars against lowlanders making incursions into their mountain strongholds (Westermeyer, Vang & Lyfong, Note 3). The use of the Lao language may be seen by the Hmong as an insult. Thus, separate Hmong versions were developed.

The fact that many of the Indochinese clients were illiterate in their own language led to variations in the methods of data collection for at least one of the instruments used--the Walton and Brantner Depression Scale for Cross-Cultural Use. Literate clients filled out their own forms while illiterate clients were asked the items verbally. How these different methods of data collection affect these results is not known. However, Westermeyer, Neider and Vang (1984) found no differences between literate and illiterate subjects filling ot the Zung

Scale for Depression and the SCL-90 using similar methods of administration.

Possible Areas of Inaccuracy Due to Cross-Cultural Issues

Information on the age, income and psychiatric history of Southeast Asian refugees are examples of some areas which may not be as accurate as data collected from other populations in different situations. Westermeyer, Vang and Lyfong (Note 3) found that 42% of their sample of 97 Minnesota Hmong refugees reported either increasing or decreasing their age by 4 to 6 years on American records, in order to facilitate their move to the U.S. In addition, Hmong do not record their birthdate nor celebrate annual birthdays so their actual age is probably more of an estimate than would be obtained among people who record and celebrate birthdays.

Information on income may also be biased; most probably income is likely to be underestimated. Refugees may be reluctant to report accurate figures on income or employment because they fear it may affect cash assistance from the government. Some may have committed welfare fraud or engaged in the marketing of gold, diamonds and other jewlery in order to raise cash for survival (Yu & Lui, 1985). They may not understand or believe a researcher's guarantee of confidentiality regarding their income.

Finally, information on psychiatric illness may be difficult to obtain. Nguyen (1982) reports it is difficult to gather reliable information on psychiatric illness in family and collaterals; most of the 56 clients interviewed denied a family history of mental illness. This information may be difficult to obtain for many reasons including shame

regarding mental illness, cultural differences in concept of mental illness, and fear of such admission affecting their refugee status in this country.[2]

Southeast Asian Concepts of Mental Health

Major mental illness is highly stigmatized in Southeast Asian cultures (Nguyen, 1982a). A mentally ill person is often considered an individual born under an unlucky star or a person who is meant to suffer the consequences of misdeeds in previous lives or those committed by parents and ancestors (Nguyen, 1982a). As for minor mental illnesses, most Southeast Asians feel obliged by their culture to be strong in the face of adversity and present a strong front, so as not to betray their weaknesses. Their culture stresses harmony in interpersonal relationships and does not encourage the feeling or expression of negative feelings. Little external help outside of the family is expected for minor emotional problems and conflicts are usually handled within a small circle of relatives or friends (Nguyen, 1982a). While similar attitudes toward mental illness are found among Americans, as well, these attitudes appear to be more prevalent among Southeast Asians.

Because of these attitudes, the collection of data from the refugee clients about mental health problems and issues was problematic. The option of hiring independent bilingual interviewers was discarded because it was felt that refugee clients would not be willing to disclose such personal material to an unknown research interviewer. Thus, the decision to use the bilingual counselors, who were providing treatment, as data collectors was made. This strategy had several other advantages including utilizing their interviewing and clinical skills. There are

also disadvantages with this approach which have been discussed in the research literature and include the counselor's tendency to maximize the benefits of counseling.

Scale Validity

An important issue in cross-cultural research is the question of the appropriate range for scales. Brislin, Lonner and Thorndike (Note 4) suggest using short simple sentences of less than 16 words and avoiding scales with more than three response alternatives when translating into another language.

These recommendations were followed, as much as possible, in this evaluation project. The major factors contributing to the choice of the Walton and Brantner Depression Scale for Cross-Cultural Use, was its brevity, its use of simple, short sentences and its use of a true-false response format, rather than a more complicated response scale. High rates of illiteracy among this refugee sample necessitated a heavy reliance on interview or oral data collection procedures. These factors make suggestions regarding translation even more important.

Face validity of the instruments used is also particularly important in an evaluation study among a population that is unfamiliar with with research. Clients should feel that the data being collected is clearly appropriate and relevant to the treatment they will be receiving. The interviewers, the bilingual counselors, should also feel the data collected is relevant to the treatment they are providing and an accurate measure of the effectiveness of their skills.

Preliminary Results

Sociodemographic Description of the Two Samples

Tables 2-6 present a sociodemographic description of the Southeast Asian clients of the two agencies. Table 2 illustrates the ethnic groups represented. Both agencies have sizeable numbers of Hmong clients. Agency 2, in particular, is located in a public housing project with a sizeable Hmong population. This client sample is notable for its preponderance of Hmong and its relatively few numbers of Vietnamese.

Table 2
Ethnicity of Southeast Asian Clients
from Two Mental Health Agencies

	Ethnic Groups									
	Cambodian		Lao		Hmong		Vietnamese		Total	
	N	%	N	%	N	%	N	%	N	%
Agency 1	3	6	13	27	22	45	11	22	49	100
Agency 2	43	45	--	--	41	43	12	13	96	100

Table 3 shows that both agencies see slightly more men than women.

Table 3
Sex of Southeast Asian Clients in Two Mental Health Agencies

	Sex					
	Female		Male		Total	
	N	%	N	%	N	%
Agency 1	23	47	26	53	49	100
Agency 2	41	43	55	57	96	100

The employment figures presented in Table 4 are shockingly low, but not unusual for the Southeast Asian refugee population. Less than 20% (16% and 19% for Agency 1 and 2) were employed when they came seeking help. Large percentages in both agencies were either students or homemakers. In particular, Agency 2 had a large number of clients who were attending school. Westermeyer, Vang & Lyfong (Note 3) found high unemployment figures (approximately 50%) among a more general sample of Hmong in Minnesota.

Table 4
Employment Status of Southeast Asian Clients from Two Mental Health Agencies

	Employment Status							
	Employed		Student/ Homemaker		Unemployed		Total	
	N	%	N	%	N	%	N	%
Agency 1	8	16	16	33	25	51	49	100
Agency 2	18	19	57	60	20	21	95	100

Tables 5 and 6 provide further information on the poor economic status of the Southeast Asian clients; 57% and 71% of the clients seeking help at Agency 1 and 2, respectively, were receiving some form of public assistance. Mean gross family income was $5,706 and $6,344, respectively. These incomes supported families with a mean of 3.8 and 3.5 dependents. These figures seem unbelievably low and may not be totally accurate, for reasons discussed earlier.

Table 5
Frequencies of Southeast Asian Clients Receiving Public Assistance

	Yes		No		Total	
	N	%	N	%	N	%
Agency 1	28	57	21	43	49	100
Agency 2	69	71	28	29	97	100

Table 6
Sociodemographic Description of Southeast Asian Clients of Two Mental Health Agencies

	Agency 1		Agency 2	
	Mean	SD	Mean	SD
Sociodemographic Variables				
Age in years	38.6	15.5	33.4	14.87
Gross family income	$5,706	3,144	$6,344	3,453
Number of dependents on income	3.8	2.1	3.5	2.4
English ability	1.7[a]	.94	1.7[a]	.82
Literacy in native language	2.6[a]	1.5	2.6[a]	1.20
Number of years in U.S.	4.9	1.65	3.2	4.83
Number of face-to-face counseling contacts	3.3	2.2		

[a]Rated on a 5-point scale with 1 = very poor, 2 = poor, 3 = fair, 4 = good, 5 = very good

Table 6 also indicates that the English-ability of the clients is poor (x=1.7) and their literacy in their native language averages between "poor" and "fair" on a 5-point scale.

"Traumatic" Events

Table 7 presents the percentages of Southeast Asian clients who reported experiencing any one of 12 "traumatic events." The most common

event is "living in refugee camps" with 94% and 91% of the clients from Agency 1 and 2, respectively, reporting this experience. Other common experiences include the death of family members, loss of possessions, long separation from family members, and escaping. The mean number of events experienced is 4.9 for clients of Agency 1 and 4.4 for clients of Agency 2.

Table 7
Percentages of Clients Experiencing Traumatic Events Within the Past 10 years

Traumatic Events	Rank	Agency 1 %	Agency 2 %
Living in refugee camps	1	94	91
Death of family members	2	78	68
Loss of possessions	3	50	63
Long separation from immediate family members	4	50	61
Attempting to escape/escaping	5	62	33
Being a soldier	6	42	16
Being tortured	7	14	43
Watching family/friends tortured	8	30	24
Long separation from spouses	9	22	16
Imprisonment	10	20	11
Being wounded	11	10	7
Divorce	12	8	3
		$\bar{X}$ SD	$\bar{X}$ SD
Total number of items		4.9 2.2	4.4 2.1

Problems

Table 8 presents the five most frequent and severe problems of clients as assessed by the bilingual counselors. The ranking of the severity of the problems was very similar for Agency 1 and 2; both agencies reported a simila configuration of problems. Depression/sadness was the most severe problem among the clients of both agencies and was present in over 95% of all clients

seen. Language problems, anxiety/worry, and hopelessness were also rated as quite severe and had extremely high frequencies in both client populations.

Table 8
Five Most Severe and Frequent Problems of
Southeast Asian Clients as Rated by Their Bilingual Counselors

	Agency 1		Agency 2	
Problems	Ranked by Severity	% of Clients Having Problems	Ranked by Severity	% of Clients Having Problems
Depression/sadness	1	98	1	96
Language problems	2	96	3	89
Anxiety/worry	3	98	2	92
Hopelessness	5	96	4	84
Sleep disturbance	4	94	7	58
Isolation	9	96	5	75

Table 9 presents the diagnostic categories assigned to clients by the bilingual counselors of Agency 1. Agency 2 does not use formal diagnostic categories to evaluate their clients; thus, there is no comparable information for that agency. The high prevalence of affective disorders (58%) and adjustment reactions (18%) corresponds with the high severity and frequency of depression and anxiety problems in Table 8.

Table 9

Diagnostic Categories of Southeast Asian Clients from Agency 1

	Diagnostic Category											
	Organic Disorders		Affective Disorders		Personality Disorders		Adjustment Reactions		V Codes		Other	
	N	%	N	%	N	%	N	%	N	%	N	%
Agency 1	2	4	29	58	1	2	9	18	4	8	5	10

Table 10 presents the results of correlation analysis and analysis of variance statistics examining the relationship between several client variables and response to treatment. Change scores on the Walton and Brantner Depression Scale for Cross-Cultural Use were calculated using each refugee client's pretest and posttest scores. The statistical analysis was done separately for Agency 1 and 2.

As Table 10 indicates, most of the independent variables were not significantly related to the dependent variable, treatment outcome. None of the independent variables were significantly related to treatment outcome in both agencies. This lack of consistency across the two agencies raises questions about the generality of any relationships found.

Three variables were found to be significantly related to treatment outcome for Agency 2 only. Ethnic group, being on government assistance,

and number of traumatic experiences were significantly correlated with how well refugee clients did in treatment. At this point in the analysis, the precise nature of these relationships is not clear with the exception of the number of traumatic experiences variable. The corelation coefficient of -.57 indicates that, for Agency 1, clients who report lower levels of depression after being in treatment for six months tend to report fewer traumatic experiences. Further analysis needs to be completed (e.g., contrasts and breakdown) to elucidate the relationship between ethnicity, government assistance, and treatment outcome.

Table 10
Results of Analysis of Independent Variables and Treatment Outcome[a]

Independent Variables	Agency 1	Agency 2
Gross income	ns[c]	ns[c]
Per capita income	ns[c]	ns[c]
Sex	ns[d]	ns[d]
Ethnic group	ns[d]	p .001[d]
Employment status	ns[d]	ns[d]
Government assistance	ns[d]	p .01[d]
English ability	ns[c]	ns[c]
Number of traumatic experiences	ns[c]	r = -.57 (p.001)[c]
Age of client	ns[c]	--
Time in U.S.	ns[c]	--
Number of face-to-face counseling contacts	ns[c]	--

[a]Treatment outcome is measured by pre-test - post-test change scores on Walton and Bratner's Depression Scale for Cross Cultural Use

[b]ns = not significant at $p \leq .05$

[c]Statistic used was Pearson-product-moment-correlation

[d]Statistic used at F-test for analysis of variance

Conclusions and Discussion

This discussion section will not go into as much detail as I would like. A more conplete discussion of the methodology and results of this study will be saved for a later time when data analysis is completed.

This paper has focused on the process of developing a cross-cultural evaluation of the mental health treatment of Southeast Asian refugees and the problems inherent in such a task. Even though considerable care was taken to be sensitive to the complex cross-cultural issues involved, many problems were not resolved. A revision of the evaluation design is planned to correct some of these problems, but many difficult issues still remain to be solved. Major issues of concern include: the lack of knowledge and experience with Southeast Asian refugees in the U.S., the diversity of the various Indochinese groups, the unfamiliarity of Southeast Asians with American concepts of research, the language barriers, the question of the validity of measuring American concepts and variables in a culture with very different ideas of important concepts and variables, and the very different perspectives that the Southeast Asian and American cultures have on mental health.

In spite of all these problems, we did design a study and did collect data. A preliminary analysis of that data demonstrates some interesting issues that will be highlighted.

The demographic description of the client populations of two agencies providing mental health services to Southeast Asian refugees in the Minneapolis-St. Paul metropolitan area, underscores the fact that these clients are at the bottom of the socioeconomic ladder. We will speculate

that their high unemployment rate, low incomes, and heavy reliance on public assistance is related to their relatively recent migration to this country. This is indicated by an average number of years in the U.S. of 4.9 for clients of Agency 1 and 3.2 years for clients of Agency 2. In addition, poor English ability and low literacy in their native language may compound the problem.

The results also clearly demonstrate the kinds of traumatic experiences these refugees have experienced. Over 90% of the clients have lived in refugee camps for some length of time. Other frequent experiences include the death of family members, loss of possessions, long separations from family members and escaping. Even a less frequent event like "being tortured" was experienced by 14% and 43% of the clients in Agencies 1 and 2, respectively.

Virtually all clients of the two agencies had symptoms of depression, anxiety and hopelessness. Other researchers have found similarly high rates of depression symptoms and/or illness among Southeast Asian clients. The prevalence of depression and anxiety among these Indochinese clients may be a hopeful sign. There is some evidence from samples of American (presumably caucasian) mental health clients, that symptoms of depression and anxiety at the start of treatment, improve the most with treatment. However, whether these tentative findings apply to Southeast Asian clients, is an open question.

A multitude of studies have been done examining the relationship between client variables such as social class, educational status, age, sex, personality factors and treatment outcome. This therapy outcome research is notable for its lack of consistent findings (Garfield, 1978).

For example, in a review of five studies dealing with the social class of clients, two studies found no relationship between social class of the client and success in treatment, two found a positive relationship and one study found that lower socioeconomic status was associated with positive outcome in brief psycho-therapy (Luborsky, Chandler, Auerbach, Cohen, and Bachrach, cited in Garfield, 1978). Very little has been done to examine how ethnicity and/or minority status affects these relationships. For example, does age or sex help predict treatment outcome among Hispanics, blacks, or Southeast Asians?

Our preliminary results tend to show that, for Southeast Asians in our two client samples, factors such as income, employment, age, length of treatment, english ability, and length of time in U.S. do not appear to be related to treatment outcome (as measured by lower levels of depression on a 20-item scale). Ethnic group, receiving government assistance and number of traumatic experiences were related to outcome for only one of two mental health agencies. These relationships are tenuous ones and may primarily be due to some specific factors peculiar to Agency 2. At any rate, further analysis of our data needs to be done to "tease out the meaning", if any, in these findings. For now, it is safer to conclude that, like outcome research among primarily Caucasian-American samples, the relationship between client variables and treatment outcome is a complex and elusive one among Southeast Asian refugees.

Footnotes

[1]The intricies of these political issues were not clearly articulated to me by my Hmong translator/collaborators. I have often felt that I had to know the correct answer to my question in order to figure out the appropriate question to ask. The difficulties of cross-cultural communication in a language not native to the refugee have been more difficult than anticipated.

[2]Certain mental conditions (i.e., mental retardation, past or present insanity, severe personality disorders, including chronic alcoholism and drug addiction) are "excludable conditions," as defined by the Immigration and Nationality Act, and can affect a refugee's ability to be approved for resettlement in the United States (Robinson, 1980)

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